



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HARRIS METHODIST FT WORTH  
3255 W PIONEER PKWY  
FORT WORTH TX 76013

#### **Respondent Name**

J C PENNEY CORP INC

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-07-2138-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "...this claim was denied for not being filed within the 95 day time frame. This claim was in fact filed in a timely manner. We billed AIG 5/27/06, only 2 weeks after the DOS. According to the TWCC guidelines a bill is considered received 2 days after the date mailed."

**Amount in Dispute:** \$1,128.75

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The records of Requestor show an original bill was apparently generated on May 27, 2006 as alleged by Requestor. Those same records reveal the original bill was sent to the wrong address and had the wrong ID number for the patient... These errors were not discovered by Requestor and corrected until August 26, 2006. Carrier does not have record of receiving a bill for these services until the August 26, 2006 bill... This billing was not timely and properly submitted for payment. This case should be dismissed and/or the Requestor take nothing by its claim."

**Response Submitted by:** Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2006	Outpatient Physical Therapy	\$1,128.75	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the

absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 27, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 8, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 1 – (29) the time limit for filing has expired.

### **Findings**

1. The insurance carrier denied disputed services with reason code 1 – “(29) the time limit for filing has expired.” 28 Texas Administrative Code §133.20(b), effective May 2, 2006, 31 *Texas Register* 3544 states, in pertinent part, that “A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” The requestor's position statement asserts that “This claim was in fact filed in a timely manner. We billed AIG 5/27/06, only 2 weeks after the DOS.” However, review of the transaction log submitted by the requestor finds notations that on August 26, 2006 “UB RETURNED WRONG ADDRESS” AND “CARRIER INVALID ADDRESS.” No documentation was found to support that a medical bill was submitted to the insurance carrier within 95 days from the date the services were provided. This denial reason is supported. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
  - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
  - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this

dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the medical bills were not timely submitted to the insurance carrier in accordance with the requirements of 28 Texas Administrative Code §133.20. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

#### **Authorized Signature**

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	February 1, 2012 Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**